MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

SPECIFICATIONS FOR THE UB-92 (ELECTRONIC MEDIA CLAIM, VERSION 5.0) CLAIM TRANSACTION

December 20, 2001

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

SUMMARY OF CHANGES

This document has been revised to incorporate electronic claim requirements for Home Health Agencies and Hospice Providers as defined by the Michigan Department of Community Health's Uniform Billing Project (UBP), effective February 1, 2002.

Further, detailed revisions have been made for all provider types to input record specifications for the following Record Types:

- Input Record Type 30 – Third Party Payer. Revised to provide direction for reporting required third party liability.
- Input Record Type 40 – Claim –TAN Occurrence. Field 2 corrected for defining the sequential numbering process and Field 9 for references.
- Input Record Type 61 – Fields 4, 5, 14, 15, 24, and 25 were changed to provide reference for valid revenue and procedure codes.

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FOREWORD

This document contains the layouts and specifications of input records for the record types shown in the Table of Contents. These record types are used to bill Medicaid using the electronic form of the UB-92, also known as the Electronic Media Claim (EMC) version 5.0.

All UB-92 (EMC 5.0) claims submitted to Medicaid require the MDCH proprietary header and trailer records in accordance with File Transfer Control Protocol. The Medicaid Electronic Billing Manual contains details on the required header and trailer records.

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INPUT RECORD LAYOUT

RECORD NAME: Processor Data		RECORD TYPE: 01		RECORD SIZE: 192	
FIELD	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 01	X(2)	L	01	02
2	Submitter EIN	9(10)	R	03	12
3	Multiple Provider Billing Tape Indicator	9(1)	R	13	13
4	Filler	X(17)	L	14	30
5	Receiver Type Code	X(1)		31	31
6	Receiver ID	9(5)	R	32	36
7	Receiver Sub Identification	X(4)	L	37	40
8	Filler	X(6)	L	41	46
9	Submitter Name	X(21)	L	47	67
10	Submitter Address	X(18)	L	68	85
11	Submitter City	X(15)	L	86	100
12	Submitter State	X(2)	L	101	102
13	Submitter Zip	X(9)	L	103	111
14	Submitter Fax Number	9(10)	L	112	121
15	Country Code	X(4)	L	122	125
16	Submitter Telephone No	9(10)	R	126	135
17	File Sequence & Serial No	X(7)	L	136	142
18	Test/Production Indicator	X(4)	L	143	146
19	Filler (National Use)	X(8)	L	147	154
20	Processing Date (CCYYMMDD)	9(8)	R	155	162
21	Vendor Code/version	X(8)	L	163	170
21a	Filler	X(19)	L	171	189
22	Version Code (050)	X(3)	L	190	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "01"
2	3-12 9(10)	**Submitter EIN** This field must contain the federally assigned Employer Identification Number (EIN), also referred to as Tax Identification Number (TIN), of the submitter
3	13-13 9(1)	**Multiple Provider Billing Tape Indicator** This field must contain one of the following codes indicating whether bills for more than one provider are contained on this tape. 1= Single Provider 2= Multiple Providers
4	14-30 X(17)	**Filler** This field should be space filled.
5	31-31 X(1)	**Receiver Type Code** This field must contain the following code to indicate this file contains claims for only one payer. D= Medicaid file only.
6	32-36 9(5)	**Receiver Identification** This field must equal "00111".
7	37-40 X(4)	**Receiver Sub Identification** This field should be space filled.
8	41-46 X(6)	**Filler** This field should be space filled.
9	47-67 X(21)	**Submitter Name** This field must contain the name of the provider, billing service, or other organization to which the receiver/processor should direct inquiries regarding this file.
10	68-85 X(18)	**Submitter Address** This field must contain the mailing address of the submitter of this file (address).
11	86-100 X(15)	**Submitter City** Same as above (City).

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
12	101-102 X(2)	**Submitter State** Same as above (State).
13	103-111 X(9)	**Submitter Zip** Same as above (Zip).
14	112-121 9(10)	**Submitter Fax Number** This field should contain the fax number, including the area code, at which the submitter wishes to be contacted for claim development.
15	122-125 X(4)	**Country Code** This field will be space filled until further notice.
16	126-135 9(10)	**Submitter Telephone Number** This field should contain the telephone number, including the area code, at which the submitter wishes to be contacted for claim development.
17	136-142 X(7)	**File Sequence and Serial Number** This field should contain a “1.”
18	143-146 X(4)	**Test/production Indicator** This field should be space filled until further notice.
19	147-154 X(8)	**Filler** This field should be space filled.
20	155-162 9(8)	**Processing Date** This field must contain the date the submitter prepared the file (CCYYMMDD).
21	163-170 X(8)	**Vendor ID** This field should be space filled until further notice.
21a	171-189 X(19)	**Filler** This field should be space filled.
22	190-192 X(3)	**Version Code** This field must contain “050.”

NOTES: Regarding Record Type 01:

- Must be the first record on the file.
- Must be followed by a Record Type 10.

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INPUT RECORD LAYOUT

RECORD NAME: Provider		RECORD TYPE: 10		POSITION	
FIELD	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 10	X(2)	L	01	02
2	Type of Batch	X(3)	L	03	05
3	Batch Number	9(2)	R	06	07
4	Federal Tax Number	9(10)	R	08	17
5	Federal Tax Sub ID	X(4)	L	18	21
6	Medicare Provider Number	X(13)	L	22	34
7	Medicaid Provider Number	X(13)	L	35	47
8	Champus Insurer Provider Number	X(13)	L	48	60
9	Blue Cross/Blue Shield Provider Number	X(13)	L	61	73
10	Other Insurer Provider Number	X(13)	L	74	86
11	Provider Telephone Number	9(10)	R	87	96
12	Provider Name	X(25)	L	97	121
13	Provider Address	X(25)	L	122	146
14	Provider City	X(14)	L	147	160
15	Provider State	X(2)	L	161	162
16	Provider Zip Code	X(9)	L	163	171
17	Provider Fax Number	9(10)	R	172	181
18	Country Code	X(4)	L	182	185
19	Filler (National Use)	X(4)	L	186	189
20	Filler (Local Use)	X(2)	L	190	191
21	Source of Payment Code	X(1)	R	192	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "10."
2	3-5 X(3)	**Type of Bill** The Michigan Uniform Billing manual contains valid codes.
3	6-7 9(2)	**Batch Number** This field must contain a number assigned by the provider, sequentially from 01 to 99 to each batch of bills of a given type.
4	8-17 9(10)	**Federal Tax Number** This field should contain the federally assigned Employer Identification Number (EIN), also referred to as Tax Identification Number (TIN), of the provider in whose name the billing is taking place. Not required.
5	18-21 X(4)	**Federal Tax Sub ID** This field should contain the Federal Tax Sub ID of the provider in whose name the billing is taking place. Not required.
6	22-34 X(13)	**Medicare Provider Number** This field must contain the number assigned to a provider by the HCFA R/O for Medicare identification purposes. Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
7	35-47 X(13)	**Medicaid Provider Number/Type** This field must contain the number assigned to a provider by the Medicaid State Agency for identification. This field is divided as follows:
7A	35-36	Provider Type Code Valid codes include: 15 = Home Health Agencies, Hospice Providers 21 = Mental Health Clinics, Area Agencies on Aging 22 = State hospitals (inpatient) 30 = General hospitals (inpatient) 40 = General hospitals (outpatient) End-state renal dialysis facilities
7B	37	Filler
7C	38-44	Provider ID Number
7D	45-47	Filler
8	48-60 X(13)	**Champus Provider Number** This field may contain the number assigned to a provider by the Champus agency for identification. Not required.
9	61-73 X(13)	**Blue Cross/Blue Shield Provider Number** This field may contain the five-digit number assigned by Blue Cross (BCBSM) to the provider. Not required.
10	74-86 X(13)	**Other Insurer Provider Number** This field may be space filled.
11	87-96 9(10)	**Provider Telephone Number** This field should contain the telephone number, including the area code, at which the provider wishes to be contacted for the claim development.
12	97-121 X(25)	**Provider Name** This field must contain the name of the provider submitting this batch of bills.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
13	122-146 X(25)	**Provider Address** This field must contain the current mailing address of the provider (address).
14	147-160 X(14)	**Provider City** Same as above (city).
15	161-162 X(2)	**Provider State** Same as above (state).
16	163-171 X(9)	**Provider Zip Code** Same as above (zip).
17	172-181 9(10)	**Provider Fax Number** This field should contain the fax number, including the area code, of the provider submitting the batch.
18	182-185 X(4)	**Country Code** This field should be space filled until further notice.
19	186-189 X(4)	**Filler** This field should be space filled. (Reserved for future National use.)
20	190-191 X(2)	**Filler** This field should be space filled. (Reserved for future Local use.)
21	192-192 X(1)	**Source of Payment Code** This field must contain the following code to indicate the source of payment associated with this batch of claims. D = Medicaid

NOTE: Record Type 10:

- Must follow Record Type 01 or 95.
- Must be followed by Record Type 20.

INPUT RECORD LAYOUT

RECORD NAME: Patient		RECORD TYPE: 20		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 20	X(2)	L	01	02
2	Filler	X(2)	L	03	04
3	Patient Control Number	X(20)	L	05	24
4	Patient Last Name	X(20)	L	25	44
5	Patient First Name	X(9)	L	45	53
6	Patient Middle Initial	X(1)	L	54	54
7	Patient Sex	X(1)		55	55
8	Patient Birth Date	9(8)	R	56	63
9	Patient Marital Status	X(1)		64	64
10	Type of Admission	X(1)		65	65
11	Source of Admission	X(1)		66	66
12	Patient Address – Line 1	X(18)	L	67	84
13	Patient Address –Line 2	X(12)	L	85	96
14	Patient City	X(15)	L	97	111
15	Patient State	X(2)	L	112	113
16	Patient Zip	X(9)	L	114	122
17	Admission Date	9(8)	R	123	130
18	Admission Hour	X(2)	L	131	132
19	Statement Covers Period From	9(8)	R	133	140
20	Statement Covers Period Thru	9(8)	R	141	148
21	Patient Status As Of Statement Covers Thru Date	9(2)	R	149	150
22	Discharge Hour	X(2)	L	151	152
23	Payment Received Patient	S9(8)V99	R	153	162
24	Estimated Amount Due Patient	S9(8)V99	R	163	172
25	Medical Record Number	X(17)	L	173	189
26	Filler (National Use)	X(3)	L	190	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "20."
2	3-4 X(2)	**Filler** This field should be space filled.
3	5-24 X(20)	**Patient Control Number** This field must contain a unique patient's number assigned by the provider to facilitate retrieval of individual case records and posting of payments. Only the first 14 characters will be entered into the IP System and appear on the paper and tape Remittance Advice.
4	25-44 X(20)	**Patient Last Name** This field must contain the last name of the patient as reflected on the provider's records. It must contain at least two alphabetic characters and must not contain any embedded spaces or special characters.
5	45-53 X(9)	**Patient First Name** This field must contain the first name of the patient as reflected on the provider's records. It must contain at least one alphabetic character and must not contain any embedded spaces or special characters.
6	54-54 X(1)	**Patient Middle Initial** This field should contain the middle initial of the patient (if available) as reflected on the provider's records. If none, space fill.
7	55-55 X(1)	**Patient Sex** This field must contain a code designating the patient's gender as recorded at the date of admission or date of first service. M- Male F- Female
8	56-63 9(8)	**Patient Birth Date** This field must contain the date of birth of the patient (CCYYMMDD).

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
9	64-64 X(1)	**Patient Marital Status** This field should contain one of the following codes defining the marital status of the patient at the time of admission or service, or space fill. S=Single M=Married X=Legally Separated D=Divorced W=Widowed U=Unknown If Patient Relationship to insured (Record 30 Field 18) is “03”, Code “M” is invalid. If Patient Relationship to Insured (record 30 Field 18) is “02”, Code “D” is invalid. Not Required.
10	65-65 X(1)	**Type of Admission** This field must contain the code indicating the nature of the admission for this inpatient stay according to the following coding scheme. Space fill for outpatient claims. 1=Emergency 2=Urgent 3=Elective 4=Newborn
11	66-66 X(1)	**Source of Admission** The field must contain the code indicating the source of this admission. The Michigan Uniform Billing manual contains valid codes.
12	67-84 X(18)	**Patient Address – Line 1** This field must contain the mailing address of the patient at the time of admission.
13	85-96 X(12)	**Patient Address – Line 2** If the address exceeds more than one line, this field should contain the balance.
14	97-111 X(15)	**Patient City** Same as above (city).
15	112-113 X(2)	**Patient State** Same as above (State).

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
16	114-122 X(9)	**Patient Zip** Same as above (Zip).
17	123-130 9(8)	**Admission Date** This field must contain the date the patient was admitted for inpatient care, or the start of care date for outpatient treatment (CCYYMMDD). This date must be less than or equal to the first service date in Field 19 below. This date must be less than or equal to the system run date.
18	131-132 X(2)	**Admission Hour** This field should contain the hour of admission to inpatient care. Outpatient space fill. (Midnight = 00, Noon = 12).
19	133-140 9(8)	**Statement Covers Period From** This field must contain the beginning service date of the period covered by this bill (CCYYMMDD). The “From” date, in this field, must be a valid date, must not be greater than the “Thru” date in Field 20 , below, and for inpatient claims, must be greater than or equal to the Admission date in Field 17, above. This date must be less than or equal to the system run date.
20	141-148 9(8)	**Statement Covers Period Thru** This field must contain the ending service date of the period covered by this bill (CCYYMMDD). The “Thru” date in this field must be a valid date and must be greater than or equal to Field 19 above. This date must be less than or equal to the system run date. Outpatient- this date must be equal to the from date unless series billing.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
21	149-150 9(2)	**Patient Status as of Statement Covers Thru Date** This field must contain the numeric code indicating the patient status as of the statement covers through date according to the following coding scheme: 01-discharged to home or self care (routine discharge) 02-Discharged/transferred to another short-term general hospital 03-Discharged/transferrred to skilled nursing facility (SNF) 04-Discharged/transferred to intermediate care facility (ICF) 05-Discharged/transferred to another type of institution 06-Discharged/transferred to home under care of organized home health service organization 07-Left against medical advice 08-Discharged to Home IV service 20-Expired (or did not recover- Christian Science Patient) 30-Still patient/expected to return for outpatient care 50-Hospice- Home 51-Hospice- Medical Facility
22	151-152 X(2)	**Discharge Hour** This field must contain the hour of discharge from inpatient care. (Midnight = 00 Noon = 12) Outpatient space fill.
23	153-162 S9(8)V99	**Payment Received, Patient** This field should contain the amount the patient has paid the provider toward the bill (i.e. patient-pay amount). Not required.
24	163-172 S9(8)V99	**Estimated Amount Due, Patient** This field should contain the amount due the provider by the patient. Not required.
25	173-189 X(17)	**Medical Record Number** This field should contain a unique patient's number assigned by the provider to facilitate retrieval of the individual medical records. If the Patient Control Number (Field 3) is the same as the MRN, repeat the number in this field.
26	190-192 X(3)	**Filler** This field should be space filled.

NOTES: Regarding Record Type 20:

- Must follow either Record Type 10 or 90.
- Must be followed by Record Type 21, 22, or 30.
- All records following to Record Type 90 must have the same patient control number.

INPUT RECORD LAYOUT

RECORD NAME: Non-Insured Employment		RECORD TYPE: 21		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 21	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Employer Name	X(24)	L	25	48
5	Employer Address	X(18)	L	49	66
6	Employer City	X(15)	L	67	81
7	Employer State	X(2)	L	82	83
8	Employer Zip Code	X(9)	L	84	92
9	Employment Status Code	9(1)		93	93
10	Filler	X(15)		94	108
11	Employer Name	X(24)	L	109	132
12	Employer Address	X(18)	L	133	150
13	Employer City	X(15)	L	151	165
14	Employer State	X(2)	L	166	167
15	Employer Zip Code	X(9)	L	168	176
16	Employment Status Code	9(1)		177	177
17	Filler	X(15)		178	192

NOTE: Record Type 21 is optional for Medicaid at this time.

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "21".
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number of 01 or 02 assigned to individual records within the same specific Record Type Code to indicate the sequential order of the physical records within the Record Type.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-48 X(24)	**Employer Name** This field should contain the name of the employer that might or does provide health care coverage for individual identified in Record Type 20, Fields 4, 5, and 6. Not required.
5	49-66 X(18)	**Employer Address** This field should contain the address of the employer in Field 4 above (address). Not required.
6	67-81 X(15)	**Employer City** Same as above (city). Not required.
7	82-83 X(2)	**Employer State** Same as above (state). Not required.
8	84-92 X(9)	**Employer Zip Code** Same as above (zip code). Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
9	93-93 9(1)	**Employment Status Code** This field should contain one of the following codes to define the employment status of the insured. 1 = Employed full time 2 = Employed part time 3 = Not employed 4 = Self-employed 5 = Retired 6 = On active military duty 9 = Unknown Not required.
10	94-108 X(15)	**Filler** This field should be space filled.
11	109-132 X(24)	**Employer Name** If more than one employer might or does provide health care coverage for the individual identified in Record 20, Fields 4-6, the second employer name should be indicated in this field. If none, space fill Fields 11-17. Not required.
12	133-150 X(18)	**Employer Address** This field should contain the address of the employer in Field 12 (address). Not required.
13	151-165 X(15)	**Employer City** Same as above (city). Not required.
14	166-167 X(2)	**Employer State** Same as above (state). Not required.
15	168-176 X(9)	**Employer Zip Code** Same as above (zip code). Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
16	177-177 9(1)	**Employment Status Code** This field should contain one of the codes indicated in Field 9 to define the employment status of the insured, if there is more than one employer. Not required.
17	178-192 X(15)	**Filler** This field should be space filled.

NOTES: Regarding Record Type 21:

- Must follow Record Type 20 or 21.
- Must be followed by Record Type 21, 22, or 30.
- This record contains employment information pertaining to individuals not claiming insurance but who may have some insurance coverage through their employer from which the patient may be eligible for benefits. If more than two individuals are involved in this claim, a second Record Type 21 is to be used to submit the relevant employment data for the third and fourth parties.

INPUT RECORD LAYOUT

RECORD NAME: Unassigned State Form Locators		RECORD TYPE: 22		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 22	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	State Code	X(2)	L	25	26
5	Form Locator 2 (Upper)	X(29)	L	27	55
6	Form Locator 2 (Lower)	X(30)	L	56	85
7	Form Locator 11 (Upper)	X(12)	L	86	97
8	Form Locator 11 Physician Sponsor Plan (PSP) Provider ID Number	X(13)	L	98	110
9	Form Locator 56 (Upper)	X(13)	L	111	123
10	Form Locator 56 (Second)	X(14)	L	124	137
11	Form Locator 56 (Third)	X(14)	L	138	151
12	Form Locator 56 (Fourth)	X(14)	L	152	165
13	Form Locator 56 (Patient)	X(14)	L	166	179
14	Form Locator 78 (Upper)	X(2)	L	180	181
15	DRG (FL 78 Lower)	X(3)	L	182	184
16	Filler (Local use)	X(7)	L	185	191
17	Line of Business	X(1)	L	192	192

NOTE: Record Type 22 is required if applicable.

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "22".
2	3-4 9(2)	**Sequence Number** This field must contain a sequence number which will relate to the following: Sequence 01 represents the primary payer, Sequence 02 represents the secondary payer, and Sequence 03, the tertiary payer.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-26 X(2)	**State Code** This field should be space filled.
5	27-55 X(29)	**Form Locator 2 (Upper)** This field will be space filled.
6	56-85 X(30)	**Form Locator 2 (Lower)** This field will be space filled.
7	86-97 X(12)	**Form Locator 11 (Upper)** This field will be space filled.
8	98-110 X(13)	**Form Locator 11 Physician Sponsor Plan Provider ID Number** For all services where the patient is enrolled in the Physician Sponsor Plan (PSP, Level of Care Code 12), enter the physician sponsor's Medicaid Provider ID Number. (The PSP physician's name and telephone number are printed on the client's Medicaid ID Card.)
9	111-123 X(13)	**Form Locator 56 (Upper)** This field will be space filled.
10	124-137 X(14)	**Form Locator 56 (Second)** This field will be space filled.
11	138-151 X(14)	**Form Locator 56 (Third)** This field will be space filled.
12	152-165 X(14)	**Form Locator 56 (Fourth)** This field will be space filled.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
13	166-179 X(14)	**Form Locator 56 (Patient)** This field will be space filled.
14	180-181 X(2)	**Form Locator 78 (Upper)** This field will be space filled.
15	182-184 X(3)	**DRG (FL 78 Lower)** This field contains Diagnosis Related Group Code (DRG) determined by the facility for the related claim. Not required.
16	185-191 X(7)	**Filler** This field will be space filled.
17	192-192 X(1)	**Filler** This field will be space filled.

NOTES: Regarding Record Type 22:

- Must follow Record Type 20 or 21.
- Must be followed by Record Type 22 or 30.

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INPUT RECORD LAYOUT

RECORD NAME: Third Party Payer		RECORD TYPE: 30		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 30	X(2)	L	01	02
2	Sequence	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Source of Payment Code	X(1)		25	25
5	Payer Identification	9(5)	R	26	30
6	Payer Sub-Identification	X(4)	L	31	34
7	C/SSN/HIC Identification Number	X(19)	L	35	53
8	Payer Name	X(25)	L	54	78
9	Primary Payer Code	X(1)		79	79
10	Insurance Group Number	X(17)	L	80	96
11	Insured Group Name	X(14)	L	97	110
12	Insured's Last Name	X(20)	L	111	130
13	Insured's First Name	X(9)	L	131	139
14	Insured's Middle Initial	X(1)		140	140
15	Insured's Sex	X(1)		141	141
16	Release of Information Certification Indicator	X(1)		142	142
17	Assignment of Benefits Certification Indicator	X(1)		143	143
18	Patient's Relationship to Insured	9(2)	R	144	145
19	Employment Status Code	9(1)		146	146
20	Covered Days	9(3)	R	147	149
21	Non-Covered Days	9(4)	R	150	153
22	Co-Insurance Days	9(3)	R	154	156
23	Lifetime Reserve Days	9(3)	R	157	159
24	Provider Identification Number	X(13)	L	160	172
25	Payments Received	S9(8)V99	R	173	182
26	Estimated Amount Due	S9(8)V99	R	183	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain the Record Type of "30".
2	3-4 9X(2)	**Sequence** This field must contain the sequential number from 01 to 03 assigned, in ascending sequence, to individual records within the same specific Record Type code to indicate the sequence of the physical record within the Record Type. Sequence 01 will represent the primary payer, Sequence 02, the secondary payer, and Sequence 03, the tertiary payer.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-25 X(1)	**Source of Payment Code** This field must contain a code indicating the Source of Payment associated with this payer record. The Michigan Uniform Billing manual contains valid codes.
5	26-30 9(5)	**Payer Identification** This field must contain "00111" in sequence 01, 02, or 03 when field 4 = "D."
6	31-34 X(4)	**Payer Sub-Identification** This field is not required for Medicaid.
7	35-53 X(19)	**C/SSN/HIC Identification Number** This field must contain the insured's unique identification number for insurance purposes, i.e., Certificate (C), Social Security Number (SSN), Health Insurance Claim (HIC). When Source of Payment code (Field 4) = "D", enter patient's 8-digit numeric Medicaid ID Number. When Source of Payment code (Field 4) = "C", enter Medicare (HIC) number. When Source of Payment code (Field 4) does not equal "C" or "D", enter insured's unique ID for payer defined in Field 5.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
8	54-78 X(25)	**Payer Name** This field should contain the name of the payer organization from which the provider might expect some payment for this bill. When Field 4 = "D", indicate "Medicaid." When Field 4 = "C", indicate "Medicare." When Field 4 does not equal "C" or "D", indicate name for payer identified in Field 5.
9	79-79 X(1)	**Primary Payer Code** This field should contain one of the following codes identifying the reason another payer is primary to Medicare. The Michigan Uniform Billing manual contains valid codes. Not required when Source of Payment code (Field 4) = "D."
10	80-96 X(17)	**Insurance Group Number** Not required when Source of Payment code (Field 4) = "D."
11	97-110 X(14)	**Insured Group Name** Not required when Source of Payment code (Field 4) = "D."
12	111-130 X(20)	**Insured's Last Name** This field should contain the name of the individual whose name the insurance is carried. Not required when Source of Payment code (Field 4) = "D."
13	131-139 X(9)	**Insured's First Name** Same as above (first name). Not required when Source of Payment code (Field 4) = "D."
14	140-140 X(1)	**Insured's Middle Initial** Same as above (middle initial), if available. If none, space fill. Not required when Source of Payment code (Field 4) = "D."
15	141-141 X(1)	**Insured's Sex** This field should contain the code indicating the insured gender. Not required when Source of Payment code (Field 4) = "D."

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
16	142-142 X(1)	**Release of Information Certification Indicator** This field must contain a code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim. Y = Yes R = Restricted or Modified Release N = No Release Not required when Source of Payment code (Field 4) = "D."
17	143-143 X(1)	**Assignment of Benefits Certification Indicator** This field must contain one of the following codes showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y = Benefits Assigned N = Benefits Not Assigned Not required when Source of Payment code (Field 4) = "D."
18	144-145 9(2)	**Patient's Relationship to Insured** This field must contain one of the following codes indicating the relationship of the patient to the insured. The Michigan Uniform Billing manual contains valid codes. Not required when Source of Payment code (Field 4) = "D."
19	146-146 9(1)	**Employment Status Code** This field should contain one of the following codes that indicate whether the employment information given in the related areas apply to the insured. The Michigan Uniform Billing manual contains valid codes. Not required when Source of Payment code (Field 4) = "D."
20	147-149 9(3)	**Covered Days** This field must contain the accommodation days covered by the primary payer. Fields 20 and 21 should be compared to Record 20, Fields 20, 21 and 22. That is, If the Patient Status equals 30 (Still Patient), both the "From" and "Thru" dates are counted as Covered or Non-Covered Days. If the Patient Status equals 01-07 (Discharged) or 20 (Death), the "Thru" date is not counted as a Covered or Non-Covered Day. Required, when complementary to Medicare.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
21	150-153 9(4)	**Non-Covered Days** This field must contain the accommodation days not covered by the primary payer. SEE NOTE IN FIELD 20. Required, when complementary to Medicare.
22	154-156 9(3)	**Co-Insurance Days** This field contains the number of co-insurance days used for this admission. For inpatient, this field must not exceed 30 days or the number of Covered Days in Field 20 above. If Co-Insurance Days are not being used, this field should be zero filled. If days are reported Co-Insurance, Value Codes A2 or B2 must be present. Required, when complementary to Medicare.
23	157-159 9(3)	**Lifetime Reserve Days** This field contains the number of lifetime reserve days used for this admission. This field must not exceed 60 days or the number of Covered Days in Field 20 above. If Lifetime Reserve Days are not being used, this field should be zero filled. If days are reported Co-Insurance, Value Codes A2 or B2 must be present.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
24	160-172 X(13)	**Provider Identification Number** This field must contain the provider number for related payer as reported in field 4 of this record 30 sequence. When Source of Payment code (Field 4) = “D”, enter the number assigned to a provider by the Medicaid State agency for identification. This field is divided as follows:
24A	160-161	Provider Type Code Valid codes include: 15 = Home Health Agencies, Hospice Providers 21 = Mental health clinics, Area Agencies on Aging 22 = State mental hospitals (inpatient) 30 = General hospitals (inpatient) 40 = General hospitals (outpatient)
24B	162-162	Filler
24C	163-169	Provider ID Number
24D	170-172	Filler When Source of Payment code (Field 4) = “C”, enter the number assigned to a provider by Medicare. When Source of Payment code (Field 4) does not equal “C” or “D”, enter provider number assigned by payer defined in Field 5.
25	173-182 S9(8)V99	**Payment Received** This field must contain the amount the facility has received toward payment of this bill, prior to the billing date, by the payer indicated in Field 5. When Source of Payment Code (Field 4) is equal to “D’, then this field should be zero. This field is required on a third party payer record for any carrier other than Medicaid that has already paid on the claim (any other carrier Record Sequence [XX] that is less than Medicaid sequence XX).
26	183-192 S9(8)V99	**Estimated Amount Due** This field should contain the amount estimated by the provider to be due from the related payer in this sequence. Not required.

NOTES: Regarding Record Type 30:

- Must follow Record Type 20, 21, 22, 30, or 31.
- Must be followed by Record Type 30, 31, or 40.
- One third party payer record packet (Record Types 30 and 31) will appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a Record Type 30. However, each Record Type 30 may or may not have an associated Record Type 31. The sequence number in the Record Types 30 and 31 will serve as matching criterion for the specific third party payer record packet.

Example: Medicare is primary, and the secondary payer requires the insured's address and Revenue line specific authorization:

	Record Type	Sequence Number
Medicare	30	01
Secondary Payer	30	02
	31	02

Sequence 01 will always represent the primary payer.
Sequence 02 will always represent the secondary payer.
Sequence 03 will always represent the tertiary payer.

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INPUT RECORD LAYOUT

RECORD NAME: Third Party Payer		RECORD TYPE: 31		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 31	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Insured's Address- Line 1	X(18)	L	25	42
5	Insured's Address- Line 2	X(12)	L	43	54
5a	Filler	X(6)	L	55	60
6	Insured's City	X(15)	L	61	75
7	Insured's State	X(2)	L	76	77
8	Insured's Zip	X(9)	L	78	86
9	Insured's Employer Name	X(24)	L	87	110
10	Insured's Employer Address	X(18)	L	111	128
11	Insured's Employer City	X(15)	L	129	143
12	Insured's Employer State	X(2)	L	144	145
13	Insured's Employer Zip	X(9)	L	146	154
14	Form Locator 37 (ICN-DCN)	X(23)	L	155	177
15	Contractor Number	X(5)	L	178	182
16	Filler (National Use)	X(10)		183	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "31."
2	3-4 9(2)	**Sequence Number** This field must contain the numbers 01, 02, or 03. Sequence 01 will represent the primary payer, Sequence 02, the secondary payer and Sequence 03, the tertiary payer. See Record Type 30 notes regarding Sequence Number.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-42 X(18)	**Insured's Address – line 1** This field should contain the mailing address of the insured.
5	43-54 X(12)	**Insured's Address- Line 2** If the address exceeds more than one line, this field should contain the balance. Same as above.
5a	55-60 X(6)	**Filler** This field should be space filled.
6	61-75 X(15)	**Insured's City** Same as above (city).
7	76-77 X(2)	**Insured's State** Same as above (state).
8	78-86 X(9)	**Insured's Zip** Same as above (zip).
9	87-110 X(24)	**Insured's Employer Name** This field should contain the name of the employer.
10	111-128 X(18)	**Insured's Employer Address** Same as above (address).
11	129-143 X(15)	**Insured's Employer City** Same as above (city).
12	144-145 X(2)	**Insured's Employer State** Same as above (state).
13	146-154 X(9)	**Insured's employer Zip** Same as above (zip).

14	155-177 X(23)	**Form Locator 37 (ICN-DCN)** This field will contain the Claim Reference Number for the original paid claim. This number is available from the 866 Record, Field 6 for tape claims, or the Remittance Advice for paper claims.
15	178-182 X(5)	**Contractor Number** This field will be space filled until further notice.
16	183-192 X(10)	**Filler** This field is space filled.

NOTES: Regarding Record Type 31:

- Must follow Record Type 30 or 31.
- Must be followed by Record Type 40.

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INPUT RECORD LAYOUT

RECORD NAME: Claim – TAN Occurrence		RECORD TYPE: 40		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 40	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Type of Bill	X(3)	L	25	27
5	Treatment Authorization Code A	X(18)	L	28	45
6	Treatment Authorization Code B	X(18)	L	46	63
7	Treatment Authorization Code C	X(18)	L	64	81
8	Occurrence Code-1	X(2)	L	82	83
9	Occurrence Date-1	9(8)	R	84	91
10	Occurrence Code-2	X(2)	L	92	93
11	Occurrence Date-2	9(8)	R	94	101
12	Occurrence Code-3	X(2)	L	102	103
13	Occurrence Date-3	9(8)	R	104	111
14	Occurrence Code-4	X(2)	L	112	113
15	Occurrence Date-4	9(8)	R	114	121
16	Occurrence Code-5	X(2)	L	122	123
17	Occurrence Date-5	9(8)	R	124	131
18	Occurrence Code-6	X(2)	L	132	133
19	Occurrence Date-6	9(8)	R	134	141
20	Occurrence Code-7	X(2)	L	142	143
21	Occurrence Date-7	9(8)	R	144	151
22	Occurrence Span Code-1	X(2)	L	152	153
23	Occurrence Span From Date-1	9(8)	R	154	161
24	Occurrence Span Thru Date-1	9(8)	R	162	169
25	Occurrence Span Code-2	X(2)	L	170	171
26	Occurrence Span From Date-2	9(8)	R	172	179
27	Occurrence Span Thru Date-2	9(8)	R	180	187
28	Filler	X(5)	L	188	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "40."
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number from 01-99 assigned, in ascending sequence, to individual records within the same specific Record Type Code to indicate the sequence of the physical record within the Record Type. See the Notes at the end of Record Type 40 field descriptions for further information regarding more than one Record Type 40.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-27 X(3)	**Type of Bill** The Michigan Uniform Billing manual contains valid codes.
5	28-45 X(18)	**Treatment Authorization Code A** This field should contain a number or other indicator which designates the treatment covered by this bill has been authorized by the payer. The use of Fields 5, 6, and 7 is intended to relate to the number in Sequence Record 30. For example, Treatment Authorization Code A relates to the payer in Record 30 Sequence 1; Code B relates to the payer in Record 30 Sequence 2; etc. There may be an optional prior authorization numeric entry in the first 9 digits. The billing agent should verify that the first four digits are a numeric Julian date (YDDD) and the next five digits contain a valid Modulus Eleven check-digit number.
6	46-63 X(18)	**Treatment Authorization Code B** This field should contain a number or other indicator which designates the treatment covered by this bill has been authorized by the payer. The use of Fields 5, 6, and 7 is intended to relate to the number in Sequence Record 30. For example, Treatment Authorization Code A relates to the payer in Record 30 Sequence 1; Code B relates to the payer in Record 30 Sequence 2; etc. Field 5 contains instructions for prior authorization numbers.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
7	64-81 X(18)	**Treatment Authorization Code C** This field should contain a number or other indicator which designates the treatment covered by this bill has been authorized by the payer. The use of Fields 5, 6, and 7 is intended to relate to the number in Sequence Record 30. For example, Treatment Authorization Code A relates to the payer in Record 30 Sequence 1; Code B relates to the payer in Record 30 Sequence 2; etc. Field 5 contains instructions for prior authorization numbers.
8	82-83 X(2)	**Occurrence Code – 1** This field must contain one of the codes from the following scheme defining any significant event relating to this bill that may affect the payer's processing. If none, space fill. The Michigan Uniform Billing manual contains valid codes.
9	84-91 9(8)	**Occurrence Date – 1** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). If present, must be valid and less than or equal to the current date. If no code indicated in Field 8, zero fill.
10	92-93 X(2)	**Occurrence Code –2** This field must contain one of the codes identified in field 8 if more than one significant event is to be indicated, If none, space fill.
11	94-101 9(8)	**Occurrence Date – 2** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). Refer to relationship explanations identified in Field 9. If present, must be valid and less than or equal to the current date. If none, zero fill.
12	102-103 X(2)	**Occurrence Code-3** This field must contain one of the codes identified in field 8 if more than one significant event is to be indicated, If none, space fill.
13	104-111 9(8)	**Occurrence Date – 3** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). Refer to relationship explanations identified in Field 9. If present, must be valid and less than or equal to the current date. If none, zero fill.
14	112-113 X(2)	**Occurrence Code – 4** This field must contain one of the codes identified in field 8, if more than one significant event is to be indicated. If none, space fill.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
15	114-121 9(8)	**Occurrence Date – 4** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). Refer to relationship explanations identified in Field 9. If present, must be valid and less than or equal to the current date. If none, zero fill.
16	122-123 X(2)	**Occurrence Code – 5** This field must contain one of the codes identified in field 8 if more than one significant event is to be indicated. If none, space fill.
17	124-131 9(8)	**Occurrence Date – 5** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). Refer to relationship explanations identified in Field 9. If present, must be valid and less than or equal to the current date. If none, zero fill.
18	132-133 X(2)	**Occurrence Code – 6** This field must contain one of the codes identified in field 8 if more than one significant event is to be indicated. If none, space fill.
19	134-141 9(8)	**Occurrence Date – 6** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). Refer to relationship explanations identified in Field 9. If present, must be valid and less than or equal to the current date. If none, zero fill.
20	142-143 X(2)	**Occurrence Code – 7** This field must contain one of the codes identified in field 8, if more than one significant event is to be indicated. If none, space fill.
21	144-151 9(8)	**Occurrence Date – 7** This field must contain the date associated with the Occurrence Code in the preceding field (CCYYMMDD). Refer to relationship explanations identified in Field 9. If present, must be valid and less than or equal to the current date. If none, zero fill.
22	152-153 X(2)	**Occurrence Span Code – 1** This field must be space filled. Not required.
23	154-161 9(8)	**Occurrence Span From Date – 1** Not required.
24	162-169 9(8)	**Occurrence Span Thru Date – 1** Not required.
25	170-171 X(2)	**Occurrence Span Code – 2** Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
26	172-179 9(8)	**Occurrence Span From Date –2** Not required.
27	180-187 9(8)	**Occurrence Span Thru Date –2** Not required.
28	188-192 X(5)	**Filler** This field should be space filled.

NOTES: Regarding Record Type 40:

- Must follow Record Type 30, 31, or 40.
- Must be followed by Record Type 40, 41, 50, 60.
- Additional iterations of the appropriate record type, 40 or 41, may be submitted to convey additional codes. For Sequence Numbers 02 and higher, all fields — except those required to convey the additional code(s) that could not be contained in sequence 01 — are initialized to zeroes or blanks as appropriate, with the exception of the Record Type, Sequence, and Patient Control Number fields.

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INPUT RECORD LAYOUT

RECORD NAME: Claim – Condition – Value		RECORD TYPE: 41		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 41	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Condition Code – 1	X(2)	L	25	26
5	Condition Code – 2	X(2)	L	27	28
6	Condition Code – 3	X(2)	L	29	30
7	Condition Code – 4	X(2)	L	31	32
8	Condition Code – 5	X(2)	L	33	34
9	Condition Code – 6	X(2)	L	35	36
10	Condition Code – 7	X(2)	L	37	38
11	Condition Code – 8	X(2)	L	39	40
12	Condition Code – 9	X(2)	L	41	42
13	Condition Code – 10	X(2)	L	43	44
14	Form Locator 31 (Upper)	X(5)	L	45	49
15	Form Locator 31 (Lower)	X(6)	L	50	55
16	Value Code – 1	X(2)	L	56	57
17	Value Amount – 1	S9(7)V99	R	58	66
18	Value Code – 2	X(2)	L	67	68
19	Value Amount – 2	S9(7)V99	R	69	77
20	Value Code – 3	X(2)	L	78	79
21	Value Amount – 3	S9(7)V99	R	80	88
22	Value Code – 4	X(2)	L	89	90
23	Value Amount – 4	S9(7)V99	R	91	99
24	Value Code – 5	X(2)	L	100	101
25	Value Amount – 5	S9(7)V99	R	102	110
26	Value Code – 6	X(2)	L	111	112
27	Value Amount – 6	S9(7)V99	R	113	121
28	Value Code – 7	X(2)	L	122	123
29	Value Amount – 7	S9(7)V99	R	124	132
30	Value Code – 8	X(2)	L	133	134

31	Value Amount – 8	S9(7)V99	R	135	143
32	Value Code – 9	X(2)	L	144	145
33	Value Amount – 9	S9(7)V99	R	146	154
34	Value Code – 10	X(2)	L	155	156
35	Value Amount – 10	S9(7)V99	R	157	165
36	Value Code – 11	X(2)	L	166	167
37	Value Amount – 11	S9(7)V99	R	168	176
38	Value Code – 12	X(2)	L	177	178
39	Value Amount – 12	S9(7)V99	R	179	187
40	Filler (National Use)	X(5)		188	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "41".
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number from 01-99 assigned, in ascending sequence, to individual records within the same specific Record Type Code to indicate the sequence of the physical record within the Record Type. See the Notes at the end of Record Type 40 field descriptions for further information regarding more than one Record Type 41.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-26 X(2)	**Condition Code – 1** This field may contain one of the following codes defining circumstances that may relate to the adjudication of this bill. The Michigan Uniform Billing manual contains valid codes.
5	27-28 X(2)	**Condition Code – 2** If more than one condition exists, as defined in Field 4, indicate the second code in this area. If none, space fill.
6	29-30 X(2)	**Condition Code – 3** If more than two conditions exist, as defined in Field 4, indicate the third code in this area. If none, space fill.
7	31-32 X(2)	**Condition Code – 4** If more than three conditions exist, as defined in Field 4, indicate the fourth code in this area. If none, space fill.
8	33-34 X(2)	**Condition Code – 5** If more than four conditions exist, as defined in Field 4, indicate the fifth code in this area. If none, space fill.
9	35-36 X(2)	**Condition Code – 6** If more than five conditions exist, as defined in Field 4, indicate the sixth code in this area. If none, space fill.
10	37-38 X(2)	**Condition Code – 7** If more than six conditions exist, as defined in Field 4, indicate the seventh code in this area. If none, space fill.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
11	39-40 X(2)	**Condition Code – 8** If more than seven conditions exist, as defined in Field 4, indicate the eighth code in this area. If none, space fill.
12	41-42 X(2)	**Condition Code – 9** If more than eight conditions exist, as defined in Field 4, indicate the ninth code in this area. If none, space fill.
13	43-44 X(2)	**Condition Code – 10** If more than nine conditions exist, as defined in Field 4, indicate the tenth code in this area. If none, space fill.
14	45-49 X(5)	**Form Locator 31 (Upper)** This field should be space filled.
15	50-55 X(6)	**Form Locator 31 (Lower)** This field should be space filled.
16	56-57 X(2)	**Value Code – 1** This field contains one of the following codes which identifies data necessary for processing this claim as qualified by the payer organization. Codes A1-C3 must correspond to the related Record 30 Sequence. The Michigan Uniform Billing manual contains valid codes.
17	58-66 S9(7)V99	**Value Amount – 1** This field must contain the dollar amount associated with the Value Code indicated in Field 16.
18	67-68 X(2)	**Value Code – 2** If more than one Value Code exists as defined in Field 16, indicate the second code in this area. If none, space fill.
19	69-77 S9(7)V99	**Value Amount – 2** This field must contain the dollar amount associated with the Value Code indicated in Field 18. Refer to explanation in Field 17.
20	78-79 X(2)	**Value Code – 3** If more than one Value Code exists as defined in Field 16, indicate the third code in this area. If none, space fill.
21	80-88 S9(7)V99	**Value Amount – 3** This field must contain the dollar amount associated with the Value Code indicated in Field 20. Refer to the explanation in Field 17.
22	89-90 X(2)	**Value Code – 4** If more than one Value Code exists as defined in Field 16, indicate the fourth code in this area. If none, space fill.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
23	91-99 S9(7)V99	**Value Amount – 4** This field must contain the dollar amount associated with the Value Code indicated in Field 22. Refer to the explanation in Field 17.
24	100-101 X(2)	**Value Code – 5** If more than one Value Code exists as defined in Field 16, indicate the fifth code in this area. If none, space fill.
25	101-110 S9(7)V99	**Value Amount – 5** This field must contain the dollar amount associated with the Value Code indicated in Field 24. Refer to the explanation in Field 17.
26	111-112 X(2)	**Value Code – 6** If more than one Value Code exists as defined in Field 16, indicate the sixth code in this area. If none, space fill.
27	113-121 S9(7)V99	**Value Amount – 6** This field must contain the dollar amount associated with the Value Code indicated in Field 26. Refer to the explanation in Field 17.
28	122-123 X(2)	**Value Code – 7** If more than one Value Code exists as defined in Field 16, indicate the seventh code in this area. If none, space fill.
29	124-132 S9(7)V99	**Value Amount – 7** This field must contain the dollar amount associated with the Value Code indicated in Field 28. Refer to explanation in Field 17.
30	133-134 X(2)	**Value Code – 8** If more than one Value Code exists as defined in Field 16, indicate the eighth code in this area. If none, space fill.
31	135-143 S9(7)V99	**Value Amount – 8** This field must contain the dollar amount associated with the Value Code indicated in Field 30. Refer to the explanation in Field 17.
32	144-145 X(2)	**Value Code – 9** If more than one Value Code exists as defined in Field 16, indicate the ninth code in this area. If none, space fill.
33	146-154 S9(7)V99	**Value Amount – 9** This field must contain the dollar amount associated with the Value Code indicated in Field 32. Refer to the explanation in Field 17.
34	155-156 X(2)	**Value Code – 10** If more than one Value Code exists as defined in Field 16, indicate the tenth code in this area. If none, space fill.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
35	157-165 S9(7)V99	**Value Amount – 10** This field must contain the dollar amount associated with the Value Code indicated in Field 34. Refer to the explanation in Field 17.
36	166-167 X(2)	**Value Code – 11** If more than one Value Code exists as defined in Field 16, indicate the eleventh code in this area. If none, space fill.
37	168-176 S9(7)V99	**Value Amount – 11** This field must contain the dollar amount associated with the Value Code indicated in Field 36. Refer to the explanation in Field 17.
38	177-178 X(2)	**Value Code – 12** If more than one Value Code exists as defined in Field 16, indicate the twelfth code in this area. If none, space fill.
39	179-187 S9(7)V99	**Value Amount – 12** This field must contain the dollar amount associated with the Value Code indicated in Field 38. Refer to explanation in Field 17.
40	188-192 X(5)	**Filler** This field should be space filled. (National Use)

NOTES: Regarding Record Type 41:

- Must follow Record Type 40.
- Must be followed by Record Type 41, 50, or 60.
- If there is a Source of Payment Code C in Record Type 30, then there must be a Value Code of A1, B1, C, A2, B2, or C2 with a dollar amount.

INPUT RECORD LAYOUT

RECORD NAME: I/P Accommodations		RECORD TYPE: 50		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 50	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Accom. Code – 1	9(4)	R	25	28
5	Accom. Rate – 1	9(7)V99	R	29	37
6	Accom. Days – 1	9(4)	R	38	41
7	Accom. Total Charges – 1	S9(8)V99	R	42	51
8	Accom. Non Covered Charges – 1	S9(8)V99	R	52	61
9	Form Locator 49	X(4)		62	65
10	Filler	X(1)		66	66
11	Accom. Code – 2	9(4)	R	67	70
12	Accom. Rate – 2	9(7)V99	R	71	79
13	Accom. Days – 2	9(4)	R	80	83
14	Accom. Total Charges – 2	S9(8)V99	R	84	93
15	Accom. Non-Covered Charges – 2	S9(8)V99	R	94	103
16	Form Locator 49	X(4)		104	107
17	Filler	X(1)		108	108
18	Accom. Code – 3	9(4)	R	109	112
19	Accom. Rate – 3	9(7)V99	R	113	121
20	Accom. Days – 3	9(4)	R	122	125
21	Accom. Total Charges – 3	S9(8)V99	R	126	135
22	Accom. Non-Covered Charges – 3	S9(8)V99	R	136	145
23	Form Locator 49	X(4)		146	149
24	Filler	X(1)		150	150
25	Accom. Code – 4	9(4)	R	151	154
26	Accom. Rate – 4	9(7)V99	R	155	163
27	Accom. Days – 4	9(4)	R	164	167
28	Accom. Total Charges – 4	S9(8)V99	R	168	177
29	Accom. Non-Covered Charges – 4	S9(8)V99	R	178	187
30	Form Locator 49	X(4)	L	188	191
31	Filler	X(1)		192	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "50".
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number from 01-99 assigned, in ascending sequence, to individual records within the same specific Record Type Code to indicate the sequence of the physical record within the Record Type. Each physical record may contain up to four accommodations.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-28 9(4)	**Accommodations Code – 1** This field must contain one of the Accommodations Codes. (The Revenue Code Requirements Section of The Michigan Uniform Billing manual contain the revenue code tables showing which codes are billable by provider type and payer.) Before placing accommodations revenue codes in this record, they should be sorted in ascending sequence and all repetitions of the same three digit code should be combined when the rates are the same. If the rates are different (e.g., due to new fiscal year rates), the same procedure code should be repeated with the different rate.
5	29-37 9(7)V99	**Accommodations Rate – 1** This field must contain the daily rate for the related Accommodations Code.
6	38-41 9(4)	**Accommodations Days – 1** This field must contain a numeric count of the Accommodations Days in accordance with the payer's instructions.
7	42-51 S9(8)V99	**Accommodations Total Charges – 1** This field must contain the total charges for the related Accommodations Code.
8	52-61 S9(8)V99	**Accommodations Non-Covered Charges – 1** This field must contain the accommodations charges pertaining to the related revenue codes that are not covered by the primary payer, as determined by the provider. This field must be less than or equal to the Total Charges Field 7.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
9	62-65 X(4)	**Form Locator 49** This field should be space filled.
10	66-66 X(1)	**Filler** This field should be space filled.
11	67-70 9(4)	**Accommodations Code – 2** If more than one type of accommodations are involved in this billing, this field must contain the second Accommodations Code. If none, zero fill. Refer to Field 4 for other instructions regarding revenue codes.
12	71-79 9(7)V99	**Accommodations Rate – 2** This field must contain the daily rate for the related Accommodations Code. Refer to Field 5 for other instructions regarding Accommodations Rates.
13	80-83 9(4)	**Accommodations Days – 2** This field must contain a numeric count of the Accommodations Days in accordance with the payer's instructions.
14	84-93 S9(8)V99	**Accommodations Total Charges – 2** This field must contain the total charges for the related Accommodations Code.
15	94-103 S9(8)V99	**Accommodations Non-Covered Charges – 2** This field must contain the accommodations charges pertaining to the related revenue codes that are not covered by the primary payer, as determined by the provider. This field must be less than or equal to the Accommodations Total Charges Field 13. Not required.
16	104-107 X(4)	**Form Locator 49** This field should be space filled.
17	108-108 X(1)	**Filler** This field should be space filled.
18	109-112 9(4)	**Accommodations Code – 3** If more than two types of Accommodations Code are involved in this billing, this field must contain the third Accommodations Code. If none, zero fill. Refer to Field 4 for other instructions regarding revenue codes.
19	113-121 9(7)V99	**Accommodations Rate – 3** This field must contain the daily rate for the related Accommodations Code. Refer to Field 5, above, for other instructions regarding Accommodation Rates.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
20	122-125 9(4)	**Accommodations Days – 3** This field must contain a numeric count of the Accommodations Days in accordance with the payer's instructions.
21	126-135 S9(8)V99	**Accommodations Total Charges – 3** This field must contain the total charges for the related Accommodations Code.
22	136-145 S9(8)V99	**Accommodations Non-Covered Charges – 3** This field must contain the accommodations charges pertaining to the related revenue code that are not covered by the primary payer as determined by the provider. This field must be less than or equal to the Accommodations Total Charges in Field 21. Not required.
23	146-149 X(4)	**Form Locator 49** This field should be space filled.
24	150-150 X(1)	**Filler** This field should be space filled.
25	151-154 9(4)	**Accommodations Code – 4** If more than three types of accommodations are involved in this billing, this field must contain the fourth Accommodations Code. If none, zero fill. Refer to Field 4 for other instructions regarding revenue codes.
26	155-163 9(7)V99	**Accommodations Rate – 4** This field must contain the daily rate for the related Accommodations Code. Refer to Field 5 for other instructions regarding Accommodation Rates.
27	164-167 9(4)	**Accommodations Days – 4** This field must contain a numeric count of the Accommodations Days in accordance with the payer's instructions.
28	168-177 S9(8)V99	**Accommodations Total Charges – 4** This field must contain the total charges for the related Accommodations Code.
29	178-187 S9(8)V99	**Accommodations Non-Covered Charges – 4** This field must contain the accommodations charges pertaining to the related revenue codes that are not covered by the primary payer, as determined by the provider. This field must be less than or equal to the Accommodations Total Charges in Field 28. Not required.
30	188-191 X(4)	**Form Locator 49** This field should be space filled.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
31	192-192 X(1)	**Filler** This field should be space filled.

NOTES: Regarding Record Type 50:

- Must follow either Record Type 40, 41, or 50.
- Must be followed by Record Type 50, 60, or 70.
- When more than four I/P accommodations codes are being reported, Field Codes 5 through 8 should be reported on an additional Record Type 50 with a Sequence Number of 02; 9 through 12 with a Sequence Number 03; etc.
- Accommodation Rate times Days must equal the Total Charges.
- Accommodation Revenue Code must be one of the covered codes for Medicaid.

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INPUT RECORD LAYOUT

RECORD NAME: Inpatient Ancillary Services		RECORD TYPE: 60		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 60	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Ancil. Revenue Code-1	9(4)	R	25	28
5	HCPCS/HIPPS Procedure Code-1	X(5)	L	29	33
6	Modifier 1-1	X(2)	L	34	35
7	Modifier 2-1	X(2)	L	36	37
8	Ancil. Units of Service-1	9(7)	R	38	44
9	Ancil. Total Charges-1	S9(8)V99	R	45	54
10	Ancil Non-covered Charges-1	S9(8)V99	R	55	64
11	Form Locator 49	X(4)	L	65	68
12	Service/Assessment Date - 1	9(8)	R	69	76
12a	Filler	X(4)	L	77	80
13	Ancil. Revenue Code-2	9(4)	R	81	84
14	HCPCS/HIPPS Procedure Code-2	X(5)	L	85	89
15	Modifier 1-2	X(2)	L	90	91
16	Modifier 2-2	X(2)	L	92	93
17	Ancil. Units of Service-2	9(7)	R	94	100
18	Ancil. Total Charges-2	S9(8)V99	R	101	110
19	Ancil Non-covered Charges-2	S9(8)V99	R	111	120
20	Form Locator 49	X(4)	L	121	124
21	Service/Assessment Date-2	9(8)	R	125	132
21a	Filler	X(4)	L	133	136
22	Ancil. Revenue Code-3	9(4)	R	137	140
23	HCPCS/HIPPS Procedure Code-3	X(5)	L	141	145
24	Modifier 1-3	X(2)	L	146	147
25	Modifier 2-3	X(2)	L	148	149
26	Ancil. Units of Service-3	9(7)	R	150	156

RECORD NAME: Inpatient Ancillary Services		RECORD TYPE: 60		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
27	Ancil. Total Charges-3	S9(8)V99	R	157	166
28	Ancil Non-covered Charges-3	S9(8)V99	R	167	176
29	Form Locator 49	X(4)	L	177	180
30	Service/Assessment Date-3	9(8)	R	181	188
30a	Filler	X(4)	L	189	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "60."
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number from 01 to 99 assigned, in ascending sequence, to individual records within the same specific Record Type Code to indicate the sequence of the physical record within the Record Type. Each physical record may contain up to three ancillary services.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-28 9(4)	**Ancillary Revenue Code – 1** This field must contain a valid ancillary code covered by Medicaid. The Revenue Code Requirements section of The Michigan Uniform Billing manual contains the valid ancillary codes.
5	29-33 X(5)	**HCPCS- Procedure Code – 1** Not required.
6	34-35 X(2)	**Modifier –1** This field should be space filled.
7	36-37 X(2)	**Modifier – 2** This field should be space filled.
8	38-44 9(7)	**Ancillary Units of Service – 1** This field must contain the quantitative measure of the services rendered to or for the patient. This field must be numeric.
9	45-54 S9(8)V99	**Ancillary Total Charges – 1** This field must contain the total charges pertaining to the related Ancillary Revenue Code. If a code is indicated in Field 4, this field must be greater than zero.
10	55-64 S9(8)V99	**Ancillary Non-Covered Charges – 1** This field must contain the ancillary charges pertaining to the related revenue codes that are not covered by the primary payer, as determined by the provider. If charges are indicated in Field 9, this field must be less than or equal to those charges. Not required.
11	65-68 X(4)	**Form Locator 49** This field should be space filled.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
12	69-76 9(8)	**Service/Assessment Date – 1** This field may contain a date of service. If present, must be a valid date (CCYYMMDD). Date must be less than or equal to Processing Date.
12a	77-80 X(4)	**Filler** This field should be space filled.
13	81-84 9(4)	**Ancillary Revenue Code – 2** If more than one type of ancillary service is involved in this billing, this field must contain the second Ancillary Revenue Code.
14	85-89 X(5)	**HCPCS Procedure Code – 2** Not required.
15	90-91 x(2)	**Modifier 1-2** This field should be space filled.
16	92-93 X(2)	**Modifier 2-2** This field should be space filled.
17	94-100 9(7)	**Ancillary Units of Service – 2** This field must contain the quantitative measure of the services rendered to or for the patient (e.g. days, visits, miles) this field must be numeric.
18	101-110 S9(8)V99	**Ancillary Total Charges – 2** This field must contain the total charges pertaining to the related Ancillary Revenue Code. If a code is indicated in Field 13, this field must be greater than zero.
19	111-120 S9(8)V99	**Ancillary Non-covered Charges – 2** This field must contain the ancillary charges pertaining to the related revenue codes that are not covered by the primary payer, as determined by the provider. If charges are indicated in Field 18, this field must be less than or equal to those charges. Not required.
20	121-124 X(4)	**Form Locator 49** This field should be space filled.
21	125-132 9(8)	**Service/Assessment Date – 2** This field may contain a date of service. If present, must be a valid date (CCYYMMDD). Date must be less than or equal to Processing Date.
21a	133-136 X(4)	**Filler** This field should be space filled.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
22	137-140 9(4)	**Ancillary Revenue Code – 3** If more than two types of ancillary services are involved in this billing, this field must contain the third Ancillary Revenue Code.
23	141-145 X(5)	**HCPCS Procedure Code** Not required.
24	146-147 X(2)	**Modifier 1-3** This field should be space filled.
25	148-149 X(2)	**Modifier 2-3** This field should be space filled.
26	150-156 9(7)	**Ancillary units of Service – 3** This field must contain the quantitative measure of the services rendered to or for the patient. This field must be numeric.
27	157-166 S9(8)V99	**Ancillary Total Charges – 3** This field must contain the total charges pertaining to the related Ancillary Revenue Code. If a code is indicated in Field 22, this field must be greater than zero.
28	167-176 S9(8)V99	**Ancillary Non-Covered Charges – 3** This field must contain the ancillary charges pertaining to the related Revenue Codes that are not covered by the primary payer, as determined by the provider. If charges are indicated in Field 27, this field must be less than or equal to those charges. Not required.
29	177-180 X(4)	**Form Locator 49** This field should be space filled.
30	181-188 9(8)	**Service/Assessment Date – 3** This field may contain a date of service. If present, must be a valid date (CCYYMMDD). Date must be less than or equal to Processing Date.
30a	189-192 X(4)	**Filler** This field should be space filled.

NOTE: Regarding Record Type 60:

- Must follow either Record Type 40, 41, 50 or 60.
- Must be followed by either Record Type 60, 70, or 80.
- When more than three ancillary Service codes are being reported, Field Codes 4-6 should be reported on an

additional Record Type 60 with a Sequence Number of 02, 7-9 with a Sequence Number of 03, etc.

- The Inpatient Ancillary Revenue Code must be one of the covered codes for Medicaid.

INPUT RECORD LAYOUT

RECORD NAME: Outpatient Procedures		RECORD TYPE: 61		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 61	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Revenue Ctr. Code-1	9(4)	R	25	28
5	HCPCS/HIPPS Procedure Code-1	X(5)	L	29	33
6	Modifier 1-1	X(2)	L	34	35
7	Modifier 2-1	X(2)	L	36	37
8	Units –1	9(7)	R	38	44
9	Form Locator 49	X(6)	L	45	50
10	Total Charges-1	S9(8)V99	R	51	60
11	Non-covered Charges-1	S9(8)V99	R	61	70
12	Service/Assessment Date-1	9(8)	R	71	78
13	Filler	X(2)	L	79	80
14	Revenue Ctr. Code-2	9(4)	R	81	84
15	HCPCS/HIPPS Procedure Code-2	X(5)	L	85	89
16	Modifier 1-2	X(2)	L	90	91
17	Modifier 2-2	X(2)	L	92	93
18	Units –2	9(7)	R	94	100
19	Form Locator 49	X(6)	L	101	106
20	Total Charges-2	S9(8)V99	R	107	116
21	Non-covered Charges-2	S9(8)V99	R	117	126
22	Service/Assessment Date-2	9(8)	R	127	134
23	Filler	X(2)	L	135	136
24	Revenue Ctr. Code-3	9(4)	R	137	140
25	HCPCS/HIPPS Procedure Code-3	X(5)	L	141	145
26	Modifier 1-3	X(2)	L	146	147
27	Modifier 2-3	X(2)	L	148	149
28	Units –3	9(7)	R	150	156
29	Form Locator 49	X(6)	L	157	162
30	Total Charges-3	S9(8)V99	R	163	172
31	Non-covered Charges-3	S9(8)V99	R	173	182
32	Service/Assessment Date-3	9(8)	R	183	190
33	Filler	X(2)	L	191	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "61."
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number from 01 to 99 assigned, in ascending sequence, to individual records within the same specific Record Type Code to indicate the sequence of the physical record within the Record Type. Each physical record may contain up to three outpatient services.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-28 9(4)	**Revenue Ctr. Code – 1** This field must contain one of the ancillary codes (220-999) identified by Provider type and payer listed in The Michigan Uniform Billing manual. Codes should be sorted in ascending sequence. The Revenue code Requirements Section of The Michigan Uniform Billing manual contain the revenue code tables showing which codes are billable by provider type and payer. This field must contain appropriate revenue code for provider type as indicated in provider-specific manuals.
5	29-33 X(5)	**HCPCS- Procedure Code – 1** This field should contain the HCPCS Procedure Code Associated with the Revenue Code indicated in Field 4 above. If not applicable, space fill. The revenue Code Requirement Section of the Michigan Uniform Billing Manual indicates which revenue codes required corresponding HCPCS code. This field must contain appropriate procedure code for provider type as indicated in provider-specific manuals.
6	34-35 X(2)	**Modifier – 1-1** This field should be space filled.
7	36-37 X(2)	**Modifier – 2-1** This field should be space filled.
8	38-44 9(7)	**Units – 1** This field must contain the units of service.
9	45-50 X(6)	**Form Locator 49** This field should be space filled.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
10	51-60 S9(8)V99	**Total charges – 1** This filed must contain the Total Charges pertaining to the related Revenue Center Code. This field should reflect those cumulative charges for the units indicated in Field 8 above.
11	61-70 S9(8)V99	**Non-covered charges – 1** This field must contain the charges pertaining to the related Revenue Center Codes that are not covered by the primary payer, as determined by the provider. If charges are indicated in Field 10 above, this field must be less than or equal to the Total charge.
12	71-78 9(8)	**Service/Assessment Date – 1** This field may contain a date of service. If present, must be a valid date (CCYYMMDD). Date must be less than or equal to Processing Date.
13	79-80 X(2)	**Filler** This field should be space filled.
14	81-84 9(4)	**Revenue Center Code – 2** If more than one outpatient ancillary service is involved in this billing, the field must contain the second Revenue Center Code. If none, zero fill. Refer to Field 4 for other instructions regarding Revenue Center Codes.
15	85-89 X(5)	**HCPCS Procedure Code – 2** This field should contain the HCPCS Procedure Code Associated with the Revenue Code indicated in Field 14 above. If not applicable, space fill. The revenue Code Requirement Section of the Michigan Uniform Billing Manual indicates which revenue codes required corresponding HCPCS code. Refer to Field 5 for other instructions regarding HCPCS Procedure codes.
16	90-91 X(2)	**Modifier 1-2** This field should be space filled.
17	92-93 X(2)	**Modifier 2-2** This field should be space filled.
18	94-100 9(7)	**Units – 2** This field must contain the units of service. Refer to Field 8 above for further requirements.
19	101-106 X(6)	**Form Locator 49** This field should be space filled.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
20	107-116 S9(8)V99	**Total charges – 2** This file must contain the Total charges pertaining to the related Revenue Center Code. This field should reflect those cumulative charges for the units indicated in Field 18.
21	117-126 S9(8)V99	**Non-Covered Charges – 2** This field must contain the charges pertaining to the related Revenue Center Code that are not covered by the primary payer, as determined by the provider. If charges are indicated in Field 20 above, this field must be less than or equal to the Total Charge.
22	127-134 9(8)	**Service/Assessment Date – 2** This field may contain a date of service. If present, must be a valid date (CCYYMMDD). Date must be less than or equal to Processing Date.
23	135-136 X(2)	**Filler** This field should be space filled.
24	137-140 9(4)	**Revenue Center Code – 3** If more than two outpatient ancillary services are involved in this billing, this field must contain the third Revenue Center Code. If none, zero fill. Refer to Field 4, above, for other instructions regarding Revenue Center Codes.
25	141-145 X(5)	**HCPCS Procedure Code - 3** This Field should contain the HCPCS Procedure Code associated with the Revenue Center Code indicated in Field 24. If not available, space fill. Refer to Field 5 for further requirements
26	146-147 X(2)	**Modifier 1-3** This field should be space filled.
27	148-149 X(2)	**Modifier 2-3** This field should be space filled.
28	150-156 9(7)	**Units – 3** This field must contain the units of service. Refer to Field 8 above for further instructions regarding units.
29	157-162 X(6)	**Form Locator 49** This field should be space filled.
30	163-172 S9(8)V99	**Total Charges – 3** This field must contain the Total Charges pertaining to the related Revenue Center Code. This field should reflect those cumulative charges for the units indicated in Field 28.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
31	173-182 S9(8)V99	**Non-Covered Charges – 3** This field must contain the charges pertaining to the related Revenue Center Code that are not covered by the primary payer, as determined by the provider. If charges are indicated in Field 30, above, this field must be less than or equal to the Total Charge.
32	183-190 9(8)	**Service/Assessment Date – 3** This field may contain a date of service. If present, must be a valid date (CCYYMMDD). Date must be less than or equal to Processing Date.
33	191-192 X(2)	**Filler** This field should be space filled.

NOTE: Regarding Record Type 61

- Must follow either Record Type 40, 41 or 61
- Must be followed by either Record Type 61, 70, 80 or 90
- When more than three Outpatient Ancillary Service codes are being reported, Field Codes 4 - 6 should be reported on an additional Record Type 61 with a Sequence Number of “02”, 7 - 9 with a Sequence Number of “03”, etc.

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INPUT RECORD LAYOUT

RECORD NAME: Medical		RECORD TYPE: 70		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 70	X(2)	L	01	02
2	Sequence Number	9(2)	R	03	04
3	Patient Control Number	X(20)	L	05	24
4	Principle Diagnosis Code	X(6)	L	25	30
5	Other Diagnosis Code –1	X(6)	L	31	36
6	Other Diagnosis Code –2	X(6)	L	37	42
7	Other Diagnosis Code –3	X(6)	L	43	48
8	Other Diagnosis Code –4	X(6)	L	49	54
9	Other Diagnosis Code –5	X(6)	L	55	60
10	Other Diagnosis Code –6	X(6)	L	61	66
11	Other Diagnosis Code –7	X(6)	L	67	72
12	Other Diagnosis Code –8	X(6)	L	73	78
13	Principle Procedure Code	X(7)	L	79	85
14	Principle Procedure Date	9(8)	R	86	93
15	Other Procedure Code –1	X(7)	L	94	100
16	Other Procedure Date-1	9(8)	R	101	108
17	Other Procedure Code –2	X(7)	L	109	115
18	Other Procedure Date-2	9(8)	R	116	123
19	Other Procedure Code –3	X(7)	L	124	130
20	Other Procedure Date-3	9(8)	R	131	138
21	Other Procedure Code –4	X(7)	L	139	145
22	Other Procedure Date-4	9(8)	R	146	153
23	Other Procedure Code –5	X(7)	L	154	160
24	Other Procedure Date-5	9(8)	R	161	168
25	Admitting Diagnosis Code	X(6)	L	169	174
26	External Cause of Injury (E Code)	X(6)	L	175	180
27	Procedure Coding Method	9(1)		181	181
28	Filler	X(11)		182	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**RECORD TYPE** This field must contain a Record Type of "70."
2	3-4 9(2)	**Sequence Number** This field must be 01.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-30 x(6)	**Principle Diagnosis Code** This field must contain the ICD-9-CM diagnosis code of the principle condition established, after study, to be chiefly responsible for the occasioning the accommodations and/or services billed on this record. Include "V" codes, as appropriated. No decimal points may be included. Use detail level codes rather than the general category code. "E" codes will not be accepted and very few "V" codes are allowed.
5	31-36 X(6)	**Other Diagnosis Code – 1** If more than one diagnosis code is being reported, this field must contain the second ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
6	37-42 X(6)	**Other Diagnosis Code – 2** If more than two diagnosis codes are being reported, this field must contain the third ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
7	43-48 X(6)	**Other Diagnosis Code – 3** If more than three diagnosis codes are being reported, this field must contain the fourth ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
8	49-54 X(6)	**Other Diagnosis Code – 4** If more than four diagnosis codes are being reported, this field must contain the fifth ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
9	55-60 X(6)	**Other Diagnosis Code – 5** If more than five diagnosis codes are being reported, this field must contain the sixth ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
10	61-66 X(6)	**Other Diagnosis Code – 6** If more than six diagnosis codes are being reported, this field must contain the seventh ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
11	67-72 X(6)	**Other Diagnosis Code – 7** If more than seven diagnosis codes are being reported, this field must contain the eighth ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
12	73-78 X(6)	**Other Diagnosis Code – 8** If more than eight diagnosis codes are being reported, this field must contain the ninth ICD-9-CM diagnosis code of any condition other than the principle diagnosis. No decimal points may be included. Refer to payer notes in Field 4. Not required.
13	79-85 X(7)	**Principle Procedure Code** This field must contain the ICD-9-CM procedure code identifying the principle surgical procedure (if any) performed during the period covered by this billing. If a code is indicated in this field, a date must be indicated in Field 14.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
14	86-93 9(8)	**Principle Procedure Date** This field must contain the date (CCYYMMDD) on which the principle surgical procedure was performed, according to the patient's medical record. If date is indicated in this field, a code must be indicated in Field 13. If none, zero fill. If indicated, the date must be valid and less than or equal to the current date.
15	94-100 X(7)	**Other Procedure Code – 1** If more than one surgical procedure was performed during this billing period, this field must contain the code to identify the procedure other than the principle one performed. If a code is indicated in this field, a date must be indicated in Field 16. Refer to payer notes in Field 13.
16	101-108 9(8)	**Other Procedure Date – 1** This field must contain the date (CCYYMMDD) on which the secondary surgical procedure was performed, according to the patient's medical record. If a date is indicated in this field, a code must be indicated in Field 15. If none, zero fill. If indicated, the date must be valid and less than or equal to the current date.
17	109-115 X(7)	**Other Procedure Code – 2** If more than two surgical procedures were performed during this billing period, this field must contain the procedure code to identify the second procedure other than the principle one performed. If a code is indicated in this field, a date must be indicated in Field 18 below. Refer to payer notes in Field 13. Not required.
18	116-123 9(8)	**Other Procedure Date – 2** This field must contain the date (CCYYMMDD) on which the second, secondary surgical procedure was performed, according to the patient's medical record. If a date is indicated in this field, a code must be indicated in Field 17. If none, zero fill. If indicated, the date must be valid and less than or equal to the current date. Not required.
19	124-130 X(7)	**Other Procedure Code – 3** If more than three surgical procedures were performed during this billing period, this field must contain the procedure code to identify the third procedure other than the principle one performed. If a code is indicated in this field, a date must be indicated in Field 20 below. Refer to payer notes in Field 13. Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
20	131-138 9(8)	**Other Procedure Date – 3** This field must contain the date (CCYYMMDD) on which the third, secondary surgical procedure was performed, according to the patient's medical record. If a date is indicated in this field, a code must be indicated in Field 19. If none, zero fill. If indicated, the date must be valid and less than or equal to the current date. Not required.
21	139-145 X(7)	**Other Procedure Code – 4** If more than four surgical procedures were performed during this billing period, this field must contain the code to identify the fourth procedure other than the principle one performed. If a code is indicated in this field, a date must be indicated in Field 22 below. Refer to payer notes in Field 13. Not required.
22	146-153 9(8)	**Other Procedure Date – 4** This field must contain the date (CCYYMMDD) on which the fourth, secondary surgical procedure was performed, according to the patient's medical record. If a date is indicated in this field, a code must be indicated in Field 21. If none, zero fill. If indicated, the date must be valid and less than or equal to the current date. Not required.
23	154-160 X(7)	**Other Procedure Code – 5** If more than five surgical procedures were performed during this billing period, this field must contain the code to identify the fifth procedure other than the principle one performed. If a code is indicated in this field, a date must be indicated in Field 24 below. Refer to payer notes in Field 13. Not required.
24	161-168 9(8)	**Other Procedure Date – 5** This field must contain the date (CCYYMMDD) on which the fifth, secondary surgical procedure was performed, according to the patient's medical record. If a date is indicated in this field, a code must be indicated in Field 23. If none, zero fill. If indicated, the date must be valid and less than or equal to the current date. Not required.
25	169-174 X(6)	**Admitting Diagnosis Code** This field should contain the admitting diagnosis code.
26	175-180 X(6)	**External Cause of Injury** This field should contain the E code for the related claim, if applicable. Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
27	181-181 9(1)	**Procedure Coding Method Used** This field must contain the code indicating the procedure code used by the provider. Not required.
28	182-192 X(11)	**Filler** This field should be space filled.

NOTES: Regarding Record Type 70:

- Must follow either Record Type 50, 60, or 61.
- Must be followed by either Record Type 70, 80 or 90.

INPUT RECORD LAYOUT

RECORD NAME: Physician		RECORD TYPE: 80		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 80	X(2)	L	01	02
2	Sequence	9(2)	L	03	04
3	Patient Control Number	X(20)	L	05	24
4	Physician Number Qualifying Codes	X(2)	L	25	26
5	Attending/Requesting Physician Number	X(16)	L	27	42
6	Operating Physician Number	X(16)	L	43	58
7	Other Physician Number	X(16)	L	59	74
8	Other Physician Number	X(16)	L	75	90
9	Attending/Requesting Physician Name	X(25)	L	91	115
10	Operating Physician Name	X(25)	L	116	140
11	Other Physician Name	X(25)	L	141	165
12	Other Physician Name	X(25)	L	166	190
13	Filler	X(2)		191	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "80."
2	3-4 9(2)	**Sequence** This field must contain a sequence number beginning with 01 to relate to payer requirements in Record 30. Sequence 01 will always relate to the primary payer. If the secondary payer uses a different physician identification numbering scheme from the primary payer, show the secondary payer's physician identification number on the 02 Sequence record. If a primary payer requests multiple physician numbers, use a sequence number 11; for secondary use 12, etc. If the tertiary payer uses a different physician ID numbering scheme, show the tertiary physician's ID Number in the 03 sequence record.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient number indicated in the previous Record Type 20 for this patient's claim.
4	25-26 X(2)	**Physician Number Qualifying Codes** This field should contain a code which defines the numbering scheme used for the Physician number. UP = UPIN SL = State License ID FI = Federal Taxpayer ID Number SP = Specialty License Number Not required.
5	27-42 X(16)	**Attending/Requesting Physician Number** This field must contain the 7 digit Provider ID Number to identify the attending physician and the 2 digit provider type. If the physician is not enrolled with Medicaid, enter "8888888" in the first seven positions. See the **Medical Assistance Program Hospital Manual**, Appendix E, for a list of enrolled providers.
6	43-58 X(16)	**Operating Physician Number** This field should contain the number used by the provider to identify the operating physician. Not required.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
7	59-74 X(16)	**Other Physician Number** This field should contain the number used by the provider to identify another licensed physician, other than attending and operating, involved with this claim (if any). The format of the number is the same as indicated in Field 5.
8	75-90 X(16)	**Other Physician Number** This field should contain the number used by the provider to identify a second other licensed physician, other than attending and operating, involved with this claim (if any). The format of the number is the same as indicated in Field 5.
9	91-115 X(25)	**Attending/Requesting Physician Name** Enter the physician's last name, one space, first name, one space, and middle initial.
10	116-140 X(25)	**Operating Physician Name** This field should contain the name of the Operating Physician (if any) as identified in the patient's medical record. Not required.
11	141-165 X(25)	**Other Physician Name** This field should contain the name of another licensed physician other than attending and operating (if any) involved with this claim.
12	166-190 X(25)	**Other Physician Name** This field should contain the name of a second other licensed physician (if any) other than attending and operating, involved with this claim.
13	191-192 X(2)	**Filler** This field should be space filled.

NOTES: Regarding Record Type 80.

- Must follow either Record Type 50, 60, 61, 70.
- Must be followed by Record Type 81 or 90.
- Physician Numbers must have a numeric digit in the first 7 digits that passes the check digit routine. There can also be all "8's" in the field.
- If the Physician Number is all 8's, then the Physician's Name is also required.

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INPUT RECORD LAYOUT

RECORD NAME: Claim Control		RECORD TYPE: 90		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 90	X(2)	L	01	02
2	Filler	X(2)	L	03	04
3	Patient Control Number	X(20)	L	05	24
4	Physical Record Count	9(3)	R	25	27
5	Record Type 2n Count	9(2)	R	28	29
6	Record Type 3n Count	9(2)	R	30	31
7	Record Type 4n Count	9(2)	R	32	33
8	Record Type 5n Count	9(2)	R	34	35
9	Record Type 6n Count	9(2)	R	36	37
10	Record Type 7n Count	9(2)	R	38	39
11	Record Type 8n Count	9(2)	R	40	41
12	Record 91 Qualifier	9(1)	R	42	42
13	Accommodations Total Charges	S9(8)V99	R	43	52
14	Accommodations Total Non-Covered Charges	S9(8)V99	R	53	62
15	Ancillaries Total Charges	S9(8)V99	R	63	72
16	Ancillaries Total Non-Covered Charges	S9(8)V99	R	73	82
17	Remarks	X(110)	L	83	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "90."
2	3-4 X(2)	**Filler** This field should be space filled.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-27 9(3)	**Physical Record Count** (excluding screen) This field must contain the total number of records submitted for this bill, including all Record Types 20-80, and excluding Record Type 90.
5	28-29 9(2)	**Record Type 2n Count** This field must contain a count of the Record Type 20 – 29 for this bill.
6	30-31 9(2)	**Record Type 3n Count** This field must contain a count of the Record Type 30 – 39 for this bill.
7	32-33 9(2)	**Record Type 4n Count** This field must contain a count of the Record Type 40 – 49 for this bill.
8	34-35 9(2)	**Record Type 5n Count** This field must contain a count of the Record Type 50 – 59 for this bill.
9	36-37 9(2)	**Record Type 6n Count** This field must contain a count of the Record Type 60 – 69 for this bill.
10	38-39 9(2)	**Record Type 7n Count** This field must contain a count of the Record Type 70 – 79 for this bill.
11	40-41 9(2)	**Record Type 8n Count** This field must contain a count of the Record Type 80 – 89 for this bill.
12	42-42 9(1)	**Record 91 Qualifier** This field must contain a "1" if there is a Record Type 91.
13	43-52 S9(8)V99	**Accommodations Total Charges** This field must contain the total accommodation charges for this bill, as reflected in Record Type 50, and subsequent accommodation packets in Record Type 50.

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
14	53-62 S9(8)V99	**Accommodations Total Non-Covered Charges** This field must contain the total of accommodation charges not covered by the primary payer for this bill as reflected in Record Type 50, and subsequent accommodation packets in Record Type 50. If charges are reported in Field 13, this field must be less than or equal to the total charge. Not required.
15	63-72 S9(8)V99	**Ancillaries Total Charges** This field must contain the total ancillary charges for this bill as reflected in Record Type 60 or 61 and subsequent ancillary packets in Record Type 60 or 61.
16	73-82 S9(8)V99	**Ancillaries Total Non-Covered Charges** This field must contain the total of ancillary charges not covered by the primary payer for this bill as reflected in Record Type 60 or 61 and subsequent ancillary packets in Record Type 60 or 61. If charges are reported in Field 15, this field must be less than or equal to the total charge. Not required.
17	83-192 X(110)	**Remarks** This field should contain any comments pertinent to this patient's bill which you feel will help clarify matters of concern to the primary payer. For Type of Bill xx7 and xx8, enter the reason for adjustment (e.g., overpayment on original claim). For hysterectomy claims: When the patient required the hysterectomy due to a life-threatening emergency situation and was unable to sign a DSS-2218 (Acknowledgement of Receipt of Hysterectomy Information), state what the life-threatening situation was, and that it was not possible for the physician to inform the patient in advance that the surgery would result in permanent sterility. When the patient was sterile prior to the hysterectomy, enter the cause of sterility (e.g., post menopausal, previous tubal ligation).

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
17 (cont'd)	83-192 X(110)	When at the time the hysterectomy was performed the patient was not eligible for Medicaid but eligibility was subsequently made retroactive, state retroactive eligibility, no DSS-2218 was signed, patient was informed prior to surgery that it would result in permanent sterility. For inpatient medical hospital claims requiring prior authorization: When the authorization number was obtained using the mother's I.D. number, enter the words: "P.A. number obtained using mother's I.D." When an admission, readmission, transfer, or continued stay period occurred during a period of retroactive Medicaid eligibility, enter "retroactive eligibility." **NOTE**: An admitting history and physical, face sheet, and discharge summary must be attached to the claim. For claims when the stay spans a period where there was a change in ownership of the facility, a change in the patient's Medicaid eligibility, or a change in the programs for which the patient was eligible, enter the appropriate circumstance (e.g., "change in ownership"). For claims with Condition Code X2 or X4, enter the insurance carrier's name and contract number. Indicate the reason the service was not covered. For claims where an auto insurance or Worker's Disability Compensation claim has been filed, enter the auto insurance carrier's name, or Worker's Disability Compensation carrier, employer, and attorney if available. For claims where the patient is 65 years or older and has not met the residence requirement, enter, "Alien" and the date and port of entry. For claims where additional payment is being requested, enter the reason. For claims billing leave day revenue codes, enter the dates of the leave days. For claims when hospital personnel accompany a patient on an ambulance transfer, enter the identification and credentials of the hospital personnel (e.g., nurse), reason for the transport, mileage, and amount of time that the hospital personnel were involved in the ambulance transport.

NOTE: Regarding Record Type 90:

- Must follow either Record Type 50, 60, 61, 70, or 80.
- Must be followed by either Record Type 20, 91, or 95.

INPUT RECORD LAYOUT

RECORD NAME: Remarks		RECORD TYPE: 91		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 91	X(2)	L	01	02
2	Sequence Number	9(2)	L	03	04
3	Patient Control Number	X(20)	L	05	24
4	Remarks (Additional)	X(82)	L	25	106
5	Filler (National use)	X(86)		107	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "91."
2	3-4 9(2)	**Sequence Number** This field must contain the sequential number from 01 to 99, assigned in ascending sequence, to individual records within the same specific Record Type code to indicate the sequence of its physical record within the Record Type.
3	5-24 X(20)	**Patient Control Number** This field must contain the same unique patient's number indicated in the previous Record Type 20 for this patient's claim.
4	25-106 X(82)	**Remarks (Additional)** The first 110 characters of Remarks are to be reported in Record 90 Field 17. Any additional remarks should be reported in this field.
5	107-192 X(86)	**Filler** This field should be space filled (National use).

NOTE: Regarding Record Type 91:

- Must follow Record Type 90.
- Must be followed by Record Type 20 or 95.

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INPUT RECORD LAYOUT

RECORD NAME: Batch Control		RECORD TYPE: 95		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 95	X(2)	L	01	02
2	Federal Tax Number	9(10)	R	03	12
3	Receiver Identification	9(5)	R	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Type of Batch	X(3)	L	22	24
6	Number of Claims	9(6)	R	25	30
7	Filler	X(6)	R	31	36
8	Accommodations Total Charges for Batch	S9(10)V99	R	37	48
9	Accommodations Non-Covered Charges for Batch	S9(10)V99	R	49	60
10	Ancillaries Total Charges for Batch	S9(10)V99	R	61	72
11	Ancillaries Total Non-Covered Charges for Batch	S9(10)V99	R	73	84
12	Filler	X(54)		84	138
13	Filler	X(54)		139	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type "95."
2	3-12 9(10)	**Federal Tax Number** This field must contain the federally assigned Employer Identification Number (EIN), also referred to a Tax Identification Number (TIN) of the provider in whose name the billing is taking place.
3	13-17 9(5)	**Receiver Identification** This field must equal "00111".
4	18-21 X(4)	**Receiver Sub-Identification** This field must be space filled.
5	22-24 X(3)	**Type of Batch** This field must contain the same batch code indicated in the preceding Record Type 10, Field 2.
6	25-30 9(6)	**Number of Claims** This field must contain a count of the number of Record Type 20 entries for this provider batch (Record Type 10 to Record Type 95).
7	31-36 X(6)	**Filler** This field should be space filled.
8	37-48 S9(10)V99	**Accommodations Total Charges** This field must contain the sum of charges recorded in the related fields in Record Type 90, Field 13 for this provider batch.
9	49-60 S9(10)V99	**Accommodations Non-Covered Charges** This field must contain the sum of charges recorded in the related fields in Record Type 90, Field 14 for this provider batch.
10	61-72 S9(10)V99	**Ancillaries Total Charges** This field must contain the sum of charges recorded in the related fields in Record Type 90, Field 15 for this provider batch.
11	73-84 9(10)V99	**Ancillaries Total Non-Covered Charges** This field must contain the sum of charges recorded in the related fields in Record Type 90, Field 16 for this provider batch.
12	85-138 X(54)	**Filler** This field should be space filled. (Reserved for National use)
13	139-192 X(54)	**Filler** This space should be space filled. (Reserved for Local use)

NOTES: Regarding Record Type 95:

- Must follow Record Type 90 or 91.
- Must be followed by either Record Type 10 or 99.

INPUT RECORD LAYOUT

RECORD NAME: File Control		RECORD TYPE: 99		RECORD SIZE: 192 POSITION	
FIELD #	FIELD NAME	PICTURE	JUSTIFIED	FROM	THRU
1	Record Type 99	X(2)	L	01	02
2	Submitter EIN	9(10)	R	03	12
3	Receiver Identification	9(5)	R	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Number of Batches Billed This File	9(4)	R	22	25
6	Accommodations Total Charges for File	S9(11)V99	R	26	38
7	Accommodations Total Non-Covered Charges for File	S9(11)V99	R	39	51
8	Ancillary Total Charges for File	S9(11)V99	R	52	64
9	Ancillary Total Non-Covered Charges for File	S9(11)V99	R	65	77
10	Filler	X(58)		78	135
11	Filler	X(57)		136	192

INPUT RECORD SPECIFICATIONS

FIELD	LOCATION & POSITION	FIELD NAME AND DESCRIPTION
1	1-2 X(2)	**Record Type** This field must contain a Record Type of "99".
2	3-12 9(10)	**Submitter EIN** This field must contain the federally assigned Employer Identification Number (EIN), also referred to as Tax Identification Number (TIN), of the submitter.
3	13-17 9(5)	**Receiver Identification** This field must equal "00111".
4	18-21 X(4)	**Receiver Sub-Identification** This field must contain be space filled.
5	22-25 9(4)	**Number of Batches Billed This File** This field must contain a count of the number of batches billed on this file. This should equal the number of Record Type 10's on this file.
6	26-38 S9(11)V99	**Accommodations Total Charges** This field must contain the total of the accommodations charges billed on this file. This is a sum of the charges in all Record Type 95, Field 8.
7	39-51 S9(11)V99	**Accommodations Total Non-Covered Charges** This field must contain the total of the accommodations non-covered charges billed on this file. This is a sum of the charges in all Record Type 95, Field 9.
8	52-64 S9(11)V99	**Ancillary Total Charges** This field must contain the total of the ancillary charges billed on this file. This is a sum of the charges in all Record Type 95, Field 10.
9	65-77 S9(11)V99	**Ancillary Total Non-Covered Charges** This field must contain the total of the ancillary non-covered charges billed on this file. This is a sum of the charges in all Record Type 95, Field 11.
10	78-135 X(58)	**Filler** This field should be space filled. (Reserved for National use)
11	136-192 X(57)	**Filler** This field should be space filled. (Reserved for Local use)

NOTES: Regarding Record Type 99:

- Must follow Record Type 95.
- Must be the last valid record on the file.